Meeting Minutes
Health Information Technology Council Meeting

May 5, 2014
3:30 – 5:00 P.M.

One Ashburton Place, 21th floor
Boston, MA

Meeting Attendees

Name	Organization	
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	Y
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Y
William Oates	*Chief Information Officer, Commonwealth of Massachusetts*	Y
David Seltz	*Executive Director of Health Policy Commission*	Y
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	Y
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Y
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	N
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	N
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Y
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Y
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Y
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	N
Jay Breines	*Executive Director, Holyoke Health Center*	Y
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	y
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	*
Margie Sipe, RN	*Performance Improvement Consultant, Massachusetts Hospital Association (MHA)*	Y
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Y
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Y
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Y
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Y
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	N
Kristin Thorn	*Acting Director of Medicaid*	Y

Guest

Name	Organization
Robert McDevitt	EOHHS
Nick Welch	EOHHS

Name	Organization
Stacy Piszcz	EOHHS
Kathleen Snyder	EOHHS
Amy Caron	EOHHS
Jennifer Monahan	MAeHC
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Ashlie Brown	EOHHS
Kris Williams	EOHHS, Office of Medicaid
Pam May	Partners
Lisa Fenichel	Consumer
Sarah Moore	Tufts MC
David Smith	MA Hospital Association
David Bachard	NEQCA
David Bowditch	EOHHS
Rick Wilson	EOHHS, Office of Medicaid
Jessica Costantino	AARP

Meeting called to order – minutes approved

The meeting was called to order by Secretary Polanowicz at 3:35 P.M.

The Council reviewed minutes of the April 7, 2014 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: IMPACT Program Update (Slides 3-49)
See slides 3-49 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the Massachusetts eHealth Institute's (MeHI) Improving Massachusetts Post-Acute Care Transfers (IMPACT) Grant was presented by Larry Garber, MD, Medical Director for Informatics at Reliant Medical Group.

(Slide 4) IMPACT- Building Care Coordination Tools for the Healthcare System of the Future – The IMPACT Grant is an Office of the National Coordinator for Health Information Technology (ONC) grant-funded project to improve care transitions in Massachusetts.

(Slide 5) The Spectrum of Care is Vast – The diagram represents the intensity of care in various treatment settings in relation to acuity of illness. Eligible Hospitals (EHs) and Eligible Professionals (EPs) that make up the Meaningful Use (MU) program are low both in frequency and intensity of care needed – providers in every other setting, including post-acute and long term care, are not under the MU umbrella.

(Slide 6) ... as are the Barriers to Care Coordination - Those care settings not included in incentive programs become data silos creating issues around transitions of care which leads to adverse events.

(Slide 7) ONC Quote – In 2011 ONC said that the single most effective way to improve the quality of care and combat adverse events is to improve transitions of care. However, long term and post-acute care were left out. Instead of billions in funding distributed for Meaningful Use, they gave a few states some money to solve the problem.

(Slide 8) IMPACT Grant – The $1.7M Challenge Grant was awarded to MeHI in February of 2011.

(Slide 9) IMPACT Objectives and Strategies – To best meet the objectives listed on the slide, Reliant considered what the data and software needs were and how best to test and assess the impact/outcomes.

(Slide 10) IMPACT Evaluation Metrics – The metrics were to look at 30 day readmission rates, resource utilization, and total cost of care.

(Slide 11) Developing National Standards to Support Long Term and Post-Acute Care (LTPAC) Needs – Traditionally when a patient transitions to another care setting, if data is sent it is pretty much what the sender wants to send. The Continuity of Care Document (CCD) is what most organizations are actively working on in order to satisfy MU. The CCD actually came from Massachusetts. There was a standard paper transfer form, a three page form used by all of the hospitals for transitions of care, and the folks at the Massachusetts Medical Society decided to turn it into an electronic document. They tuned the paper form and turned it into the Continuity of Care Record (CCR), and then Health Level Seven International (HL7) turned it into a standard (CCD).

(Slide 12) Datasets for Care Transitions - Now, instead of trying to figure out what to send by asking the senders, we can ask the receivers what they need. We developed a survey to help understand what those data needs are.

(Slide 13) 14x14 Sender to Receiver Transition Types - A grid showing who can send to whom was provided. There are well over 200 different permutations.

(Slide 14) "Receiver" Data Needs Survey – 46 different organizations completed the survey - 11 different types of organizations and 12 different types of users. They were asked about each type of transition and what they wanted to receive. Over one thousand responses were received.

(Slide 15) Findings from Survey – There are almost 200 transitions that can be lumped into five categories – reports from Outpatient testing, referrals to Outpatient testing, shared Care Encounter Summaries, Consultation Requests, and Transfer of Care Summaries.

(Slide 16) Five Transition Datasets- Datasets one and two are when someone is sent to the hospital for a test –the providers need enough information to say, "here is the test we want, here are the medications, allergies and problems" - just enough to do the procedure safely. The third and fourth are when and organization is sending someone for a consultation – the provider can say "here are the

4

questions I want you to answer." Then the specialist can report back with the evaluation. The fifth is the largest- trying to move someone from one care setting and care team to another - having someone in the hospital that is going to a home health agency, nursing home or even one Primary Care Provider (PCP) to another. In this case the new care team needs to know everything.

(Slide 17) Five Transition Datasets – The datasets build on one another- getting to the largest, the full Transfer of Care Summary.

(Slide 18) Five Transition Datasets – A diagram of the five datasets in relation to sender and receiver type was provided.

(Slide 19 & 20) Additional Contributor Input – Additional input was provided from other organizations in Massachusetts as well as nationally. The list of contributors is provided on the slides.

 (Slide 21) Additional Contributor Input – National and international input was gathered.

(Slide 22) Datasets Include Care Plan – The group realized the Care Plan is left out of a lot of things, but it is part of all of these datasets to some degree.

(Slide 23) How do they compare to CCD – The CCD now has about 175 data elements – basic transition of care needs an additional 150 elements - then to really cover for longitudinal coordination of care you need almost 3 times the data elements in the CCD. We realized there are still issues with the CCD, but things are moving in the right direction. The consolidated Clinical Document Architecture (C-CDA) has a number of different templates that can be reused, while there are others that have not yet been templated (roughly 20%).

(Slide 24) Testing the IMPACT Dataset – To evaluate the impact the dataset needed to be tested.

(Slide 25) Pilot Sites to Test the Datasets – 16 pilot sites were chosen based on the volume of patient transfers to other pilot sites as well as experience with Transitions of Care related initiatives. A list of the participants is provided on the slide.

(Slide 26) Nursing Facility Pilot Sites – A list of the eight nursing facility sites involved was provided.

(Slide 27) IMPACT Learning Collaborative Testing the Care Transitions Datasets on Paper – During testing there were several hundred patient transfers. As the patents moved to the Emergency Room (ER) we were having actual paper transported with them to see how this all would work. We also had questionnaires that were answered by both the senders and the receivers.

(Slide 28) Senders found the data – Senders found that they had almost all of the data elements requested, but may not have been sending them.

(Slide 29) Receivers got most of their needs – Only 8% of participants said it was not enough information- those were home health agencies, which need the greatest amount of information. Fewer than five data elements were missing – home health needs to know who is supplying things like oxygen tanks, and other durable medical equipment.

(Slide 30) Turning Datasets into National Standards – Oftentimes standards do not exist – as was the case here – a consolidated CDA was not good enough.

(Slide 31) New World of Standards Development – A workflow diagram of how standards are developed was provided. The IMPACT Grant started a new workgroup for longitudinal coordination of care.

(Slide 32) NYeC, Healthix, CCITINY, ASPE, S&I LCC, HL7, Lantana Update C-CDA for MU3 and 2015 EHR Certification – The standards were developed with the help of the groups listed on the slide. The Referral Note, Transfer Summary, and Care Plan were created new and the Consultation Note was updated and went through balloting. Over one thousand comments were received. In June HL7 will publish the updated, consolidated CDA.

(Slide 33) Standards Development Timeline – A timeline of standards development was provided. Standards have already been proposed for MU Stage 3, but there is still a lot of work to be done.

(Slide 34) Getting Connected: LAND & SEE – The data standards issues are solved, but now the connectivity issues need to be dealt with so that everyone can get connected.

(Slide 35) LAND & SEE –The Local Adaptor for Network Distribution (LAND) is used by dozens of organizations already. It is for those with an Electronic Health Record (EHR), helping make connectivity to the HIway easier. The other part is the Surrogate EHR Environment (SEE) for those who do not have an EHR but need something to receive messages when someone sends something via the HIway. When they want to send something, they can actually create at CDA document.

(Slide 36) Outbound LAND Transformation - The slide details how LAND works- when an EHR exports a CDA document, the LAND converter helps pass it along to the HIway so it can be sent where it needs to go.

(Slide 37) Inbound LAND Transformations - The converter also makes it easier to receive documents. When a CDA document comes in not all of it can be absorbed. The LAND can convert the document to free text which can then be sent. It is an interface that has been used for years. With Epic it is also a way to bypass their standard per transaction fee.

(Slide 38) High Level of SEE- SEE relies on Orion's webmail. When you click on the CDA attachment it opens it up in the SEE viewer, instead of viewing in a web browser. This is the tool that will allow a user to view and manipulate the document. SEE is tucked behind the HIway firewalls. It is almost live- currently in development environment with Orion – planning for beginning of June.

(Slide 39) Surrogate EHR Environment - Nursing facilities find this useful when they send patients to the ER. As part of current workflow staff fill out a Situation, Background, Assessment and Request form (SBAR) with patient information. This is the same information required for a transfer summary which they currently fill out manually. Now with SEE, staff can send the already completed SBAR and can add additional information as needed. Staff can also print out copies for the patients, family, ambulance drivers etc.

(Slide 40) Search by Patient Name – A screenshot of the search by name functionality was provided.

(Slide 41 & 42) Copy All into New Document and Copy Data from an Existing Document – A screenshot of the copy functionality in the SEE tool was provided. If a provider wants only one section of the document they can pull in just that section.

(Slide 43) Sections of Summary Document – The document is broken into sections that can be modified individually.

(Slide 44) Intuitive Data Entry for Each Section – A screenshot of the editing functionality was provided. Questions include all of the types of information identified in the surveys.

(Slide 45) Free Text Narrative can be Added Anywhere – In each section there is an option to add free text. A screenshot of the free text narrative functionality was provided.

(Slide 46) Type-Aheads Make Data Entry Easy- Many fields will auto populate to help with discreet data entry.

(Slide 47) LTPAC Communications Using LAND & SEE – A diagram of how communication works using LAND and SEE was provided.

(Slide 48) Further Testing of Dataset, LAND & SEE - When St. Vincent sends an Admit-Discharge – Transfer (ADT) message, Dr. Garber's EHR system gets a notification and automatically sends a CCD via LAND into St. Vincent's EMR. This all happens within roughly 30 seconds of the patient's registration. Starting next month they will be sending a document via the HIway to a SEE- then they will get a text message saying "you have mail" – instructing them to check their webmail. Over the next year they will look at the impact via claims data.

(Slide 49) Questions?

- Question (Secretary Polanowicz): Are there any metrics on readmissions or cost of care savings?
    - o Answer (Larry Garber): Yes - we have all of the baseline data on readmissions and total cost of care. Once we go live we will begin tracking these metrics against the baseline.
- Question (Robert Driscoll): Did any of the Skilled Nursing Facilities already have EHRs?
    - o Answer (Larry Garber): Two were able to get them during the project, but neither could create a CCD, so they will be using SEE.
- Follow-up Question (Robert Driscoll): Do you envision that they will have to do double entry?
    - o Answer (Larry Garber): Yes, some copying and pasting will happen. Overlook Visiting Nurses Association has an EHR but cannot complete the connectivity - they may be dumping out a CCD and manually attaching it. Home Health and Nursing EHRs do not have the same certification requirements/standards as other EHRs.
- Question (Karen Bell): When could a statewide roll out of this be possible?
    - o Answer (Larry Garber): I am not the one to answer that, but I want to get us live first and make sure it makes sense and works.

- Comment (John Halamka): Right now there is a lot of tension in Washington D.C. – According to some interoperability has not moved fast enough - tons of money was spent but we have not reduced admission rates. Unfortunately, a report came out recently called the Jason Report where a group of high minded thinkers basically said "this thing we did is taking too long" and proposed an alternate approach that is not practically implementable. So we need to roll this out (SEE) quickly and broadly and prove to the world that interoperability does work.
- Question (Lisa Fenichel): Is it LAND or SEE that converts to free text? How usable is that?
  - o Answer (Larry Garber): SEE. It is very usable. It depends on the EHR – not all can do a free text search. The reality is that it may not have discreet data, but it does satisfy about 85% of my needs. It's not perfect, but a great short-cut to get things flowing.

Discussion Item 2: Policy and Advisory Group Update (Slides 50&51)

See slides 50 & 51 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Policy and Advisory Group updates were presented by Micky Tripathi, President and CEO of the Massachusetts eHealth Collaborative (MAeHC).

(Slide 51) Consent Document Distributed - Version 1.0 is complete for consent. These will be working documents since organizations will implement and learn, laws will change, conventions will change and so on. A consent policy statement, a template for consent, patient education and presentations for staff have all been developed. These materials are available for all of the participants. This was a community effort between the Advisory Groups and the HIway Ops team. This closes out consent version 1.

- Comment (John Halamka): I cannot begin to say how good this material is from an operational standpoint. At Beth Israel we have already approved our documentation and sent it to the printer. Now we need to train every single employee that interacts with patients at 83 locations!
- Comment (Deborah Adair): We built the form into Epic last week. It is ready to go out and will be part of the July rollout.
- Comment (Laurance Stuntz): At MeHI there is a staff challenge to be the first to bring in a consent form from any HIway connected organization that has the consent requirements included.

Discussion Item 3: HIway Implementation & Support Update (Slides 52-65)

See slides 52 – 65 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

HIway Implementation & Support updates were presented by Manu Tandon, Secretariat Chief Information Officer of the Executive Office of Health and Human Services and Mass HIT Coordinator.

(Slide 53) HIE Trust Fund Semi-Annual Review – A list of milestones and costs was provided- all in line with the prior forecasted budget.

(Slide 54) HIway Legal Agreements – As it stands right now there are two agreements- the basic Participation Agreement (PA) (with the addendum for Phase 2) and then there is a Health Information Service Provider (HISP) Agreement. However, there are others in the works and that is complicating operationalizing onboarding. The team is looking at how to make the agreements easier and perhaps more standardized and will provide an update in July with a plan.

(Slide 55) HIway Release Schedule – There were five projects completed from a development perspective. The webmail upgrade was delivered, the Meditech Cross-Enterprise Document Reliable Interchange (XDR) Solution went live and the HISP to HISP Solution went live with the three early adopters. Work is being done now to get ready for the Healthcare Provider Portal (HPP) Release One which will allow for bulk uploading of providers. The dates will be refined as they get closer.

- Question (Laurance Stuntz): Now that the go-live for the different nodes are complete, what is the next step for use?
  - Answer (David Bowditch): For the Opioid Program the software has all been tested with the first vendor. It is available as soon as they can get the software working, it is all checked out on the HIway side. For the Cancer Node, same thing. It has been tested, but the software vendor needs to work with their users to get things going. The testing has been completed with the vendors and their software, just not with their users.
- Comment (John Halamka): The eClinicalWorks (eCW) CEO said he will make his HISP connections free- it was becoming a market nightmare thinking of it like postage stamps for emails. It is good to note that the HIway is becoming a price driver.
- Comment (Micky Tripathi): Confirmed that eCW will offer HISP connections for free. The next thing to do is to push them to open up their architecture and let customers choose their HISP.
- Comment (John Halamka): ONC is going through a transition and is revisiting its strategy. One focus is to do more with prescription monitoring and to figure out a simple single sign on (SSO) approach for monitoring prescription drug misuse.

(Slide 56) Communications & Outreach – The 1st webinar is this Thursday. It will explain the benefits of the HIway and how to enroll – there are 91 registrants so far. The consent education materials have been distributed to the early adopters. Sometime this summer there will be a new release for the HIway website.

(Slide 57) EHR Priority Vendors – A list of the top vendors in Massachusetts was provided – data is based on the EHR vendor landscape study performed by MAeHC and funded by MeHI in 2012. The priority list was compared to the list of vendors now joining the HIway and will be used on an ongoing basis to ensure the greatest numbers of providers are covered and that EOHHS is working with the EHR vendors most important to Massachusetts providers.

(Slide 58) Status with High Priority Vendors – A list of vendors and connection status was provided. This is something EOHHS will continue to update. There are only three niche vendors that EOHHS has not made contact with, but all the remaining top vendors identified in the study are either Live or in process

of being connected. In theory, if the HIway can get to 80% of vendors in the market, then we have the penetration that we need.

(Slide 59) HIway Operations Update – Five new participation agreements were signed – Bayada Home Health, Boston Medical Center, Community Substance Abuse Centers, Harvard University Health Services and SMOC Behavioral Health Services. Winchester Highland Management signed an agreement on behalf of the eLINC HISP members (eLINC stands for – "Leveraging information, improving care, networking providers, communicating with each other"). There are currently 200 organizations signed up.

(Slide 60) HIway Operations Update – A list of the 55 members that fall under the eLINC agreement was provided.

(Slide 61) HIway Operations Update – No organizations went live in April – the major focus was on software vendors HISP testing.

(Slide 62) HIway Operations Update – There was a jump in April, due in large part to Holyoke testing ADT transactions for populating the HIway Relationship Listing Service.

(Slide 63) HIway Operations Update – Right now we are on track to overshoot the connection goal of 135 organizations connected to the HIway by June 30, 2014.

(Slide 64) HISP to HISP Connectivity –Now the HISPs can talk to one another, but members of each HISP need to start testing. The two vendors in bold are the ones that have switched status from the last update. We are working with all of them at some level - discovery, testing etc. The strategy is to keep looking at the top 16 EHR vendors and the rest will come in with time.

- Comment (John Halamka): We tested with the National Institute of Standards and Technology (NIST), finished all of our certifications for the MU components (certifying Beth Israel Deaconess Longitudinal Medical Record (LMR) with the Mass HIway) and passed everything.

(Slide 65) Phase 2 Implementation Plan - In terms of the Phase 2 implementation Beth Israel Deaconess Medical Center is very close to getting HIway ADT transactions going. Holyoke is in testing right now. The dates on the slide remain the same - Tufts is around a week away, and Atrius still has some work to do.

- Comment (Secretary Polanowicz): I would like to ask Kristen to give an update on the Infrastructure Capacity Development (ICD) grants. At that last meeting we talked about using the grant cycles to help drive use of the HIway.
- Comment (Kristin Thorn): We recently posted the new annual infrastructure and capacity building grants for acute hospitals. There will be a new requirement that applicants must certify that they are using the HIway, or that they will plan to be on the HIway by February 1, 2015. If they are using Phase 1 HIway services they need to have a plan to use the Phase 2 services. Those grants are currently posted and will be up for another 2.5 weeks.

- Comment (John Halamka): I was asked this week to evaluate a new startup company. The idea is that as a patient presents somewhere, the PCP is notified that this admission event has occurred. The hardest thing to do is to get these ADT messages sent. What if the HIway could be used to send these notifications?
- Comment (Manu Tandon): Event notifications are on the road map however the Relationship Listing Service (RLS) is not rich enough yet.
- Comment (Larry Garber): The extension to that would be for Home Health because they really do not have ADT messages to send. We would like to have a mechanism that says "these are my patients."
- Comment (Manu Tandon): We need to be careful with where we go next. We don't want to become a participant's EHR.
- Question (Karen Bell): I have to say, we have really come a long way- quickly. Thank you to everyone for the hard work. My question is to the Secretary- is the exchange supporting healthcare reform? I am wondering if at some point there is an opportunity to see how well the work we are doing here aligns with work being done nationally.
  - Answer (Secretary Polanowicz): I think that this would be a great venue for that. The work here is well ahead of other places, I think in a number of these grant situations we do not take the opportunity to really tie things together. I think a good conversation for later would be to look at health reform and see if this is an enabler and so on.

Discussion Item 4: Wrap-Up (Slides 66&67)

See slides 66 & 67 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

The meeting wrap-up was presented by Manu Tandon.

The schedule for the 2014 HIT Council Meetings was provided.

- ~~January 13~~
- ~~February 3~~
- ~~March 3~~
- ~~April 7~~
- ~~May 5~~
- June 9
- July 7
- August 4
- September 8
- October 6
- November 3
- December 8

* All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21th floor, in the Matta Conference Room.

The Next HIT Council Meeting is scheduled for **June 9, 2014** from 3:30pm-5pm at One Ashburton Place, 21th floor, in the Matta Conference Room.

The HIT Council meeting was adjourned at 4:33 P.M.